STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced complaint investigation survey was conducted at this facility June 21, 2017 through June 30, 2017. The facility census the first day of the survey was 144. The survey sample totaled six residents. In addition, one sub-sampled resident was added for observation. Abbreviations/definitions used in this report are as follows: NHA-Nursing Home Administrator; DON-Director of Nursing; MD-Medical Doctor; RT-Respiratory Therapist; PT-Physical Therapist; BOM-Business Office Manager; RN-Registered Nurse; LPN-Licensed Practical Nurse; CNA-Certified Nurse's Aide; E-mail-electronic written communication; CC-carbon copy; Buttocks-backside; Cognitive-thinking, memory, reasoning; Ileiostomy-a surgical operation in which a piece of the ileum [small intestines] is diverted to an artificial opening in the abdominal wall; Shortness of Breath (SOB)-breathlessness, or shortness of breath, describes discomfort or difficulty with breathing; Respiratory rate (RR or R)-respiratory rate is the number of breaths an individuals takes per minute. The normal respiration rate for an adult at rest is 12 to 20 breaths per minute. A respiration rate under 12 or over 25 breaths per minute while resting is considered abnormal; NC (Nasal Cannula)-a device used to deliver supplemental oxygen or increased airflow to a	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/21/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 patient or person in need of respiratory help; O2-oxygen, colorless, odorless gaseous element used in medicine to help patients breath; L-liters-oxygen provided by oxygen concentrators are measured in LPM (liters per minute); Oxygen saturation (sat.)-Oxygen saturation is a measure of how much oxygen the blood is carrying; Oxygen concentrator-a medical device used to deliver oxygen; Portable oxygen tank-is an oxygen storage vessel, which is either held under pressure in gas cylinders; Titrate-the continual adjustment of a dose based on patient response. Dosages are adjusted until the desired clinical effect is achieved; Nebulizer-an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece; Nebulizer Treatment-changes liquid medication into fine mist to be inhaled directly into the lungs; Hypoxia/Hypoxic-inadequate cellular oxygenation OR deficiency in amount of oxygen reaching body tissues; Pulse oximetry-measures blood oxygen saturation levels - desired range 94% to 100%; NC-Nasal cannula, method of delivering oxygen into the nose; Pressure Ulcer (PU)-sore area of skin that develops when the blood supply to it is cut off due to pressure; Stage I PU- a reddened area of intact skin usually over a bony prominence; Stage II PU-skin blisters or skin forms an open sore. The area around the sore may be red and irritated; Assure Prism Multi-brand name; Assure Prism Multi blood glucose monitoring	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 2 system-a glucometer; Glucometer-a medical device for determining the approximate concentration of glucose in the blood; Glucose-the simple sugar that is the chief source of energy for the body; Finger Stick Blood Sugar (FSBS)-A procedure in which a finger is pricked with a lancet to obtain a small quantity of blood to measure the amount of a type of sugar, called glucose, in the blood; Super Sani-Cloth Germicidal Disposable Wipes-brand of cleaning and disinfecting wipes; MDS-Minimum Data Set (standardized assessment forms) assessment utilized in nursing homes; Progress note-clinical documentation of care and services provided to the resident by the clinical staff, including nurses and other healthcare providers; PRN-as needed.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his	F 225		9/15/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 3 or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. (4) Report to the State nurse aide registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 4 (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and review of the facility's policy, it was determined that the facility failed to identify allegations of neglect for one (R2) out of six sampled residents. These failures resulted in the lack of immediate reporting to the State Survey Agency, in accordance with State law, lack of thorough investigation and lack of protecting the residents. Findings include: The facility's policy entitled, Abuse of Residents, with revision date of December 2016, stated that each resident has the right to be free from verbal, sexual, physical and mental abuse, corporal punishment, involuntary seclusion, mistreatment, neglect and misappropriation of property. Neglect was defined when a reasonable person would conclude that a deprivation of the omitted goods and services would cause, among other things emotional distress. In section "4. Identification", indicated that staff would receive education about the behavioral and situational signals that may indicate risk for or the presence of abuse, neglect, or misappropriation of property. 6/2/17 and timed 7:11 PM - an E-mail from R2's family member to E4 (BOM) with carbon copy of the E-mail to E1 (NHA) and E2 (DON). Review of the E-mail documented two allegations of	F 225	A. For Resident R2, Ostomy site assessed and no skin issues noted. Ostomy appliance changed per orders and supplies available. Current voiding diary completed and reviewed. Resident remains with mixed continence, appropriate incontinence product in use. Resident without signs and symptoms of infection. At this time family and resident have no allegation of abuse or neglect. All future concerns for this resident will be investigated and facility will report all allegation of abuse or neglect. B. All residents have the potential to be affected by this practice. There have been no allegations of abuse or neglect since the end of this survey. C. DON or designee will analyze all concern forms to ensure all allegations of neglect or abuse are thoroughly investigated and all factual issues are resolved. All staff will be educated on policy and reporting on abuse and neglect. ATTACHMENT A D. Quality Assurance Nurse to do daily audit of all concerns to ensure all allegations of abuse and neglect are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 5 neglect. One in which R2 had experienced leaking from her ileostomy bag and R2 did not receive care or services for over one hour, as well as the facility not having the medical supplies to maintain and care for the ileostomy. The second allegation of neglect was related to R2, who was put in an adult brief and had developed an urinary tract infection. 6/2/17 and timed 8:24 PM - An E-mail reply from E2 to R2's family member, documenting, "please feel free to call me at (telephone number) so I can assist with any nursing issue." Although the facility had received the above written electronic communication from a family member of R2, there was lack of evidence that the facility identified these incidents as allegations of neglect. 6/27/17 at approximately 12:00 PM, an interview with E2 revealed that E2 contacted the 3:00-11:00 PM RN Supervisor, E6, immediately after receiving the e-mail on 6/2/17. Additionally, E2 proceeded to contact the family member for clarifications regarding the issues on 6/2/17, however, left a voicemail message for the family member to return the call. E2 related that once E2 spoke with the family member on 6/12/17 at 10:00 AM, approximately 10 days later, the family member had other concerns relating to missing wheelchair and staff member indicating that she was busy, when R2 reported to have asked for assistance and E2 documented this on the facility's Resident/Family Concern Form. E2 confirmed that upon receiving the E-mail communication on 6/2/17, she did not identify the issues documented in the 6/2/17 E-mail, as allegations of neglect. Consequently the facility failed to report, investigate and protect R2.	F 225	reported and all factual issues are resolved. Audit for 4 weeks to ensure 100% success. Then, monitor three times a week for 3 weeks to ensure continued 100% success. Then monitor once a week for 3 weeks to ensure continued 100% success. Finally, measure one time a month later to see if there is 100% success. If so, it can be concluded the problem has been successfully addressed. ATTACHMENT B	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 6 Findings reviewed on 6/30/17 at approximately 2:30 PM with NHA (E1) and E2.	F 225		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a	F 278		9/15/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 7 material and false statement. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interviews, it was determined that the assessments for one (R2) of six sampled residents, failed to accurately reflect the resident's status. Findings include: 1a. Review of R2's clinical record revealed: 4/19/17 - Wound Evaluation Form documented a presence of one, stage II pressure ulcer (PU) of the left buttock. 4/19/17 - Admission MDS assessment documented that R2 did not have any unhealed PU, although R2's above Wound Evaluation Form documented that R2 did have one, stage II PU of the left buttock. 6/26/17 at approximately 11:00 AM, an interview with E9 (LPN) who completed the above MDS assessment confirmed the inaccurate coding on the assessment. Findings reviewed on 6/30/17 at approximately 2:30 PM with NHA (E1) and E2 (DON). 1b. Review of R2's clinical record revealed: 5/10/17 - Wound Evaluation Form documented a presence of one, stage I PU of the right heel. 5/14/17 - 30 day MDS assessment documented that R2 did not have any unhealed PU, although R2's above Wound Evaluation Form documented that R2 did have one, stage I PU of the right heel.	F 278	A. Resident R2 MDS review complete and all skin issues coded accurately. B. All resident have the potential to be affected by this practice. C. In-servicing will be completed by the Director of Clinical Reimbursement to ensure the MDS coordinators have a comprehensive understanding of accurate coding. ATTACHMENT C D. Quality Assurance Nurse to do weekly audit of MDS records will be completed for accurate assessment and coding of resident pressure ulcers. These audits will be completed weekly for 4 weeks until 100% success is achieved. Then, monitor three times a week for 3 weeks to ensure continued 100% success. Then monitor once a week for 3 weeks to ensure continued 100% success. Finally, measure one time a month later to see if there is 100% success. If so, it can be concluded the problem has been successfully addressed. ATTACHMENT D	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 8 6/26/17 at approximately 11:00 AM, an interview with E9 (LPN) who completed the above MDS assessment confirmed the inaccurate coding on the assessment. Findings reviewed on 6/30/17 at approximately 2:30 PM with E1 and E2.	F 278		
F 328 SS=D	483.25(b)(2)(f)(g)(5)(h)(i)(j) TREATMENT/CARE FOR SPECIAL NEEDS (b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments (f) Colostomy, ureterostomy, or ileostomy care. The facility must ensure that residents who require colostomy, ureterostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. (g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to … prevent complications of enteral feeding including but not limited to aspiration pneumonia,	F 328		9/15/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 9 diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. (h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. (i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. (j) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that two (R2 and R4) of six sampled residents, was provided care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents ' goals and preferences received the necessary care and services related to their respiratory care needs. t The facility failed to ensure that R2 had continuous oxygen when the portable oxygen	F 328	A. Residents R2 and R4 observed during survey remain on O2 therapy with no acute respiratory issues since survey ended. Orders immediately placed to monitor portable O2 tank levels. B. All residents on O2 therapy have the potential to be affected by this practice. All residents on O2 therapy currently have orders to monitor portable O2 tank levels.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 10 tank had no oxygen. R2 was without oxygen for an unknown period of time, became short of breath and had an oxygen saturation of 78%. The facility failed to ensure that oxygen was administered to R4 as ordered. R4, who also had an order pertaining to oxygen, was observed with the oxygen tank being empty during the survey. Findings include: 1. Review of R2's clinical record revealed: 2/16/17 and timed 1:09 PM - Progress Note, by E7 (RT), documented that E7 was at the nurses station and noticed that R2 was having shortness of breath and E7 assisted R2 to her room and into the bed. E7 provided nebulizer treatment and hooked R2 to her oxygen concentrator. R2's pulse oximetry afterwards was 94% on 4 liters of oxygen. Before leaving R2's room, R2's shortness of breath resided. 6/21/17 at approximately 11AM, an interview with E7 was conducted. E7 recalled that R2's portable oxygen tank was empty when E7 observed R2 sitting at the nurses station and verbalized that the initial pulse oximetry was 78%. 6/27/17 and timed 2:09 PM - New telephone physician's order indicating continuous oxygen at 4 liters per minute via nasal cannula and to check the portable oxygen tank every 2 hours and PRN. 6/29/17 at approximately 4:00 PM, an interview with E2 (DON) revealed that the facility instituted a new process during the survey on 6/27/17, to ensure that R2 would not be without oxygen when utilizing the portable oxygen tank. The new process involved the facility evaluating the duration of the remaining oxygen in the tank for	F 328	C. All nursing staff to be educated on portable O2 tank monitoring orders. ATTACHMENT E D. Quality Assurance Nurse to do weekly audits of portable O2 tanks will be completed to ensure tank is not empty. These audits will be completed weekly until 100% success is achieved. Then, monitor three times a week for 3 weeks to ensure continued 100% success. Then monitor once a week for 3 weeks to ensure continued 100% success. Finally, measure one time a month later to see if there is 100% success. If so, it can be concluded the problem has been successfully addressed. ATTACHMENT F	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 11 the resident. Findings reviewed on 6/30/17 at approximately 2:30 PM with NHA (E1) and E2. 2. Review of R4's clinical record revealed: 4/20/17 - Untimed telephone order indicating pulse oximetry every shift, titrate oxygen to maintain oxygen saturation greater than 92%. 6/26/17 at approximately 6:00 PM, the surveyor observed R4 sitting in her electric wheelchair, in no acute respiratory distress, outside of the rehabilitation department with the oxygen gauge indicating that there was no oxygen in the portable tank. Surveyor immediately contacted E5 (PT) for assistance. 6/27/17 - Untimed new telephone order for oxygen at 2 liters per minute via nasal cannula and to check portable oxygen tank every 4 hours and PRN. 6/29/17 at approximately 4:00 PM, an interview with E2 revealed that the facility instituted a new process to ensure that the resident would not be without oxygen when utilizing the portable oxygen tank. This resulted in a new order dated 6/27/17, in which the staff would check the tank every 4 hours and PRN. Findings reviewed on 6/30/17 at approximately 2:30 PM with E1 and E2.	F 328		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program.	F 441		9/15/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 12 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 13 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and review of manufacturer information for the glucometer device, it was determined that the facility failed to ensure proper infection control techniques during glucometer use for one [SSR1] out of one residents observed. Findings include: Review of the Assure Prism Multi blood glucose monitoring system (glucometer), manufacturer information, indicated: Cleaning and disinfecting will be done between each patient and the approved product included Super-Sani-Cloth Germicidal Disposable Wipes.	F 441	A. Facility was unable to correct the action that occurred at time of observation for SSR1 B. All resident have the potential to be affected by this practice. C. Staff Development Coordinator to educate all nursing staff on manufactuer recommendation on cleaning and disinfecting glucometers. ATTACHMENT G D. Quality Assurance Nurse to conduct	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 14 During medication administration observation for SSR1 on 6/21/17 at approximately 11:30 AM, E8 (LPN) used the glucometer to obtain blood from SSR1. After using the glucometer, E8 placed the glucometer back in the medication cart drawer without cleaning and disinfecting the device. An interview immediately after the above observation with E8 confirmed that no cleaning and disinfecting of the device was completed prior to use. 6/30/17 at approximately 1:30 PM, an interview with E2 (DON) confirmed that the glucometer must be cleaned and disinfected, by using the above wipes before using the device on a resident. Findings reviewed on 6/30/17 at approximately 2:30 with NHA (E1) and E2.	F 441	random audits to ensure that nurses are following manufacturer recommendations. These audits will be completed weekly for 4 weeks until 100% success is achieved. Then, monitor three times a week for 3 weeks to ensure continued 100% success. Then monitor once a week for 3 weeks to ensure continued 100% success. Finally, measure one time a month later to see if there is 100% success. If so, it can be concluded the problem has been successfully addressed. ATTACHMENT H	
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain-	F 514		9/15/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 15 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to ensure that the clinical record for one (R2) out of six sampled residents was complete. Findings include: Cross refer F328, example 1. The following was reviewed in R2's clinical record: 2/16/17 and timed 1:09 PM - Progress Note, by E7 (RT), documented that E7 was at the nurses station and noticed that R2 was having shortness of breath and E7 assisted R2 to her room and into the bed. E7 provided nebulizer treatment and hooked R2 to her oxygen concentrator. R2's pulse oximetry after the treatment was 94% on 4 liters of oxygen. Before leaving R2's room, R2's shortness of breath subsided.	F 514	A. Facility was unable to correct this action/documentation error for R2 B. All resident have the potential to be affected by this practice. C. All staff to be in-serviced by Staff Development Coordinator on policy and procedure on change of condition and stop and watch for residents. Attachment I D. Quality Assurance Nurse to conduct random audits for stop and watch and change in condition. These audits will be completed weekly for 4 weeks until 100% success is achieved. Then, monitor three times a week for 3 weeks to ensure continued 100% success. Then monitor once a week for 3 weeks to ensure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085020	A. BUILDING _____ B. WING _____	C 06/30/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINNACLE REHABILITATION & HEALTH CENTER	3034 SOUTH DUPONT HIGHWAY SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 16 6/21/17 at approximately 11 AM, an interview with E7 was conducted. E7 recalled that R2's portable oxygen tank was empty when E7 observed R2 sitting at the nurses station and verbalized that the initial pulse oximetry was 78%. E7 confirmed upon reviewing the above note, that the initial pulse oximetry was not documented. Findings reviewed on 6/30/17 at approximately 2:30 with NHA (E1) and E2 (DON).	F 514	continued 100% success. Finally, measure one time a month later to see if there is 100% success. If so, it can be concluded the problem has been successfully addressed. Attachment J	

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Pinnacle Rehabilitation & Health Center DATE SURVEY COMPLETED: June 30, 2017

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	COMPLETION DATE
	The State Report incorporates by references and also cites the findings specified in the Federal Report. An unannounced complaint investigation survey was conducted at this facility June 21, 2017 through June 30, 2017. The facility census the first day of the survey was 144. The survey sample totaled six residents. In addition, one sub-sampled resident was added for observation.		
3201	**Regulations for skilled and intermediate care facilities**	Cross Reference POC for CMS 2567L survey completed June 30, 2017: F0225, F0278, F0328, F0441, and F0514	9/15/17
3201.1	**Scope**	Completion Date: September 15, 2017	
3201.1.2	**Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross Refer to the CMS 2567-L survey Completed June 30, 2017: F0225, F0278, F0328, F0441, and F0514		

Provider's Signature _____ Title Administrator Date 7/21/17